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# Religious Women, Medical Settings, and Moral Risk

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## Religious Women, Medical Settings, and Moral Risk

*Peggy DesAutels*

As we think about the ethical issues surrounding women and aging, it is important to ask the following questions. What do women in our society actually experience at various stages of their life cycle? Which of these experiences put women at moral risk? In what situations are women's senses of moral value and selfhood likely to be ignored or discounted? I, along with a number of feminist philosophers, advocate approaching feminist ethics by starting with women's actual situations and experiences.<sup>1</sup> No doubt, a wide variety of aging women's experiences call for moral analysis. I focus here on the medical experiences of older women with religious commitments. I argue that when older religious women find themselves in medical settings, their most deeply held values are at special risk of being disrespected and disregarded.

It may be helpful to give a few examples of ethically troubling medical situations involving older religious women.

- A woman who strongly believes that the experience of suffering and/or death is accompanied by valuable spiritual growth, and who prefers to be fully aware rather than in a drugged state as she nears the end of life, nonetheless lets her strongly assertive physician sway her into following his recommended "complete pain management" regime.
- A nun who sits on a hospital ethics committee knows that the patient in a case being discussed holds religious views similar to her own and that these views would affect the course of treatment most preferred by that patient, but fails to speak up and feels silenced by the expectation that discussions on ethics committees should remain secular.



- A patient who has in the past relied exclusively on prayer for healing and experienced what she considers to be several “spiritual” healings of serious medical conditions, now wishes to try an exclusively spiritual approach for a new “medically serious” condition, but neither her reports of past healing experiences nor her current wishes are taken seriously by her family or her physician.

These scenarios are just a few of many potential situations that can involve older religious women, medical settings, and moral risk. Below I first discuss why such situations should not be but nonetheless have been ignored by feminist and biomedical ethicists. I then analyze the significant risk to moral value and selfhood for the women in such situations. Finally, I recommend ways to address and lower these risks.

### Religious Women, Feminist Ethics, and Biomedical Ethics

To date, those writing in feminist ethics have mostly ignored the fact that many women have a strong religious orientation and close ties to religious communities.<sup>2</sup> But for feminists interested in women’s actual experience, the fact of the matter is that in the United States, over 60 percent of all adult women and over 80 percent of women over the age of 65 are members of either a church or a synagogue (*Statistical Abstract of the United States* 1997). These statistics should be of special interest to feminist ethicists for a number of reasons. First, the guiding values of religious women are likely to derive, at least in part, from their respective religious traditions. Second, the ethical decision-making processes of such women will often incorporate prayer. And third, the moral community of most significance to many older women is none other than a church community (Ozorak 1996, 25).

Why is there such avoidance by feminist ethicists in general, and feminist biomedical ethicists in particular, of the morally relevant religious commitments of so many women in our society? There are several contributing factors. An obvious one is the fact that currently both feminist ethics and biomedical ethics are embedded within the philosophical ethical tradition—a tradition with secular assumptions, secular terminologies, and secular methodologies. For example, philosophical ethicists do not assume that God exists; nor do they assume an afterlife. They do not use such phrases as “saving souls,” or “spiritual growth,” or “God’s grace.” And they advocate neither prayer nor the consulting of a religious authority as a means to making sound moral judgments. By focusing almost exclusively on philo-



sophical concepts and theories in ethical debate, philosophical ethicists attempt to avoid the difficulties associated with including dogmatic and often conflicting religious assumptions and values.

There is another contributing factor to why feminists in particular do not sympathize with religious women. A major goal of feminism is to challenge those institutional structures, group practices, and belief systems that harm women as a group. Because religious institutions are notorious for their rigid patriarchal structures and sexist views of women, feminist philosophers tend to view women who actively participate in and feel positively toward their churches/synagogues as contributing to the perpetuation of the patriarchy. As a result, many feminists neither support nor defend religious women. Rather, they encourage religious women to divest themselves entirely of their patriarchal religious institutions, socialization, and ways of thinking.

Biomedical ethicists are also influenced in a number of ways to take a secular perspective on ethical issues that arise in medical settings. Although biomedical ethics as a field was shaped originally by religious traditions, it is now influenced primarily by the philosophical and legal traditions.<sup>3</sup> Discussions center primarily on patient *rights* and universal *principles* of bioethics. Patients are encouraged to make autonomous health care decisions in light of their own values, including religious values, but public discussion of religious values and how they can or should affect medical decision making has all but disappeared.

Finally, there are reasons why religion in general is likely to be discounted in medical settings. These have to do with the fact that the practice of Western medicine is closely allied with the practices of medical *science*. Religion assumes a spiritual aspect of reality and promotes spiritual values. Science assumes a matter-based reality and promotes secular values. Because medicine is closely allied with medical science, the materialistic methodologies, assumptions, and values of science automatically take precedence over religious methodologies, assumptions, and values. Scientific practices tend to exclude the use of divine power, view human purposes as biological, and focus on mind as brain. True, many medical practitioners and scientists have private religious commitments. They may well believe in an afterlife; they may value spiritual growth or have faith that prayer can heal. But the *practice* of medicine itself focuses on and most values the use of material means and technologies to keep the body healthy (pain-free and functioning properly) in *this* life. The prestige and authority of medicine depend on its claims to scientific validity. But even if physicians' practice of medicine is viewed as science, from a patient's perspective, the funda-



mental life choices to be made are moral and spiritual ones, even when the choices concern a patient's health and medical care.

### Older Women and Religion

The typical faithful member of a church or synagogue is often stereotypically conceived of as an older woman. Just how accurate is this conception? Studies tend to corroborate that, in fact, women are more religious than men, and older persons are more religious than younger. Women pray more frequently than men, are more likely to be regular church/synagogue goers, are more apt to report having experienced a "faith" healing, and are more likely than men to view themselves as having a personal relationship with a loving God (Feltey and Paloma 1991, Ozorak 1996). Similarly, older persons pray more frequently than younger persons, are more apt to report having religious experiences, are more likely to attend church/synagogue, and are more likely than younger persons to perceive themselves as having a close relationship with God (*Statistical Abstract of the United States* 1997, Feltey and Poloma 1991).

Recent studies suggest a number of possible explanations for why women are more likely than men to be regular attendees at a church or synagogue. When interviewed about their church experiences, most women stress the centrality of caring, community, and service to others to these experiences (Ozorak 1996, 27–28). But it can still be asked why so many women choose traditional church organizations instead of other possible venues for caring and community. One plausibility is that girls are socialized to be more affiliative and conforming (Argyle and Beit-Hallahmi 1975). Another factor may be more structural. Because most women, until recently, have not worked outside the home, involvement in church has been one of the few ways to make a difference in their communities and societies (De Vaus and McAllister 1987). In addition, child-rearing has traditionally been relegated to women. Some women attend church primarily to ensure that their children attend (Lindsey 1990, Sapiro 1990).

Older persons are more likely to be religious than younger persons for some of the same reasons. When those who are now older were growing up, there were stronger general social pressures to attend church. And because many retired older persons have neither the workplace nor an at-home family, for many, their church community becomes a significant means for countering loneliness and isolation—a way to feel meaningfully

connected to others, useful, and of service. In fact, many women, both young and old, when interviewed, directly refer to their congregation, or a subset of it, as their "family" (Ozorak 1996, 25).

### Women and the Medical Community

Women in health care settings are, as Mary Briody Mahowald refers to them, the "unequal majority" (1993). More women than men interact with the medical community. One simple reason is that women live longer than men. They are also the ones who are most apt to interact with medical professionals on behalf of their children and elderly relatives. Over the past few decades, women have become increasingly dependent on medical interventions and treatments at each stage of their life cycle. They interact with the medical community for birth control prescriptions, pregnancy, childbirth, premenopausal, menopausal, and postmenopausal conditions.

Despite women making up the majority of patients, several feminist bioethicists have convincingly argued that the health care system assumes and is biased in favor of male patients. Women are at moral risk in health care settings. They are at risk of being perceived as less worthy of such tangibles as expensive treatments and research dollars and such intangibles as full consideration and respect. Feminists point out, for example, that women are less likely to receive organ transplants or aggressive heart disease treatments than are men with equivalent health difficulties (Nelson and Nelson 1996, Sherwin 1992). Feminists have also stressed the special risks that women have for being treated paternalistically. In her book entitled *No Longer Patient*, Susan Sherwin summarizes this concern:

In a sexist society where women are regularly denied the status of competent reasoners, where patients are typically women, and where physicians are mostly men, that physicians experience patients as lacking reason does not constitute reliable evidence that patients really are incapable of the reasoning that is required to arrive at reliable decisions. (1992, 142)

The point to be made here is that women's values and perspectives, regardless of whether they are secular or religious, are at special risk of being ignored or discounted in medical settings.<sup>4</sup>



## Religious Women in Medical Settings

There are a variety of conditions under which a woman might wish to have her religious beliefs or values taken into account while in a health care setting. Much will depend on her role in the medical setting and her particular religious beliefs and values. In the patient role, some women may wish to refuse medical treatment for religious reasons (e.g., those who are Christian Scientists or Jehovah's Witnesses). Others may wish to bring their beliefs to bear on treatment decisions, especially reproductive and end-of-life treatments. In the employee or volunteer role, some religious women at health care institutions (e.g., nuns, chaplains, nurses, physicians) may wish to participate in case consultations or serve on ethics committees.

There are, however, special moral risks associated with a woman's holding and attempting to assert religious-based values in a health care setting. As mentioned above, older women are even more vulnerable to these risks than younger women simply because more older women than younger are religious. I will provide two illustrations from my own experience. The first illustration comes from my observations while serving as a medical ethicist on an ethics committee at a Catholic-affiliated urban hospital. The second illustration comes from my research on Christian Science refusal cases.<sup>5</sup>

### *Religious Women on Hospital Ethics Committees*

In order to be accredited, hospitals must show that they have a mechanism for addressing ethical issues. Most have chosen to set up ethics committees as this mechanism. The makeup of these committees includes such hospital employees as physicians, nurses, chaplains, social workers, lawyers, risk managers, and administrators. Some committees also include such "outsiders" as medical ethicists from nearby universities and representative community members. These committees are charged with educating themselves and the hospital staff on medical ethics, determining ethics-related policies and procedures, and consulting on particular cases involving difficult ethical issues.

I have served as a philosopher/medical ethicist on several hospital ethics committees, including an ethics committee at a Catholic-affiliated hospital. As a medical ethicist who researches the ways that secular and religious values conflict, I was especially interested in observing how the ethics committee at the Catholic hospital addressed and resolved such conflicts. This particular committee was co-chaired by a physician with no



apparent religious commitments and a nun who directed the hospital volunteers. The committee also included a Catholic priest (chaplain), two additional Catholic nuns (chaplain and social worker), a Protestant minister (chaplain), a deeply committed Catholic woman who served as an administrator at a nearby Catholic long-term care facility, and the usual array of physicians, nurses, social workers, and so on—some of whom were Catholic and some of whom were not. Unsurprisingly, the nuns serving on this committee were older than many members of the committee.

Despite there being so many religiously committed individuals on this committee and despite the fact that the committee served a religiously affiliated hospital, I was surprised to discover that the perspectives brought to bear on the ethical deliberations of this committee were primarily secular. Rarely, if ever, did the nuns directly challenge secular assumptions that conflicted with their religious values or perspective. I recall one particular pain management discussion, for example, in which the physician leading the discussion simply assumed that pain should be avoided at all costs. This physician, like many other physicians and secular medical ethicists, held the view that such costs could include a patient becoming mentally fogged or a terminal patient's hastened death. The nuns remained silent during the meeting, but one of them mentioned to me later that she had been very disturbed by this discussion—that from her perspective not all suffering can or should be avoided. Nonetheless, she felt that it was inappropriate to bring up this religious outlook during committee deliberations.

Women's religious perspectives also exist and are also silenced on ethics committees at secular hospitals. For example, I facilitated a day-long retreat for the ethics committee of a large nonsectarian urban hospital. At the committee chair's request, most of the retreat was devoted to determining the goals and objectives of the committee for the coming year and to discussion of the latest trends in the field of bioethics. However, as a final exercise, the members of the committee were asked to share how they actually make difficult ethical decisions in their own lives. Almost every woman on the committee and many of the men reported their church to be their primary source of moral values and prayer to be their primary means to resolving ethical issues. Many also mentioned for the first time that day how confusing it is to have personal, religiously based values and approaches to ethics that often conflict with the secular values and approaches of the committee. Nevertheless, like the nuns discussed above, they too were reticent to bring religious perspectives to bear on ethics committee deliberations.



*Religious Women Who Refuse Medical Treatment*

Just as more women than men are religious, it is also the case that more women than men are likely to choose spiritual or religious alternatives to medical treatments for both themselves and their children. Such women are at high risk for being treated paternalistically within the medical community. Because physicians base their practices on the medical model of disease, choosing a healing system that directly challenges and conflicts with this medical model may well be perceived by physicians as an irrational choice. Physicians are, for the most part, well intentioned, but find it very difficult to perceive the patient's good as anything other than the good as defined from a medical perspective.

Both medical ethicists and the courts appear at first glance to eschew medical paternalism in favor of patients, both male and female, making informed, autonomous choices for themselves and their children. But a closer look at recent literature on informed consent in medical settings gives us a different and rather alarming picture. In fact, as can be seen from recent court decisions, little is expected of physicians. In his discerning comments on *Canterbury v. Spence*, Jay Katz does not exaggerate when he notes that "the law of informed consent is substantially mythic and fairy tale-like" (Katz 1994, 148). Those familiar with this court ruling know that it sanctions physicians communicating information in such a way that patients will "consent" to the treatments the physician deems best for the patient. In summary, it is considered legally and ethically acceptable for a physician to withhold or present information in a biased way under a wide variety of circumstances, including whenever the physician deems such withholding or presenting to be of therapeutic benefit.

In her discussions of paternalism, Susan Sherwin provides a number of reasons why women as a group have been and still are especially vulnerable to being treated paternalistically in medical contexts. Among these reasons, she notes that medicine has adopted the ideology of science and is fully committed to technological health care solutions in contradistinction to many women who offer "unscientific" perspectives and reports on their own health. I agree with Sherwin's analysis and simply wish further to stress that religiously oriented women with approaches to health and healing that directly challenge "scientific" and technological approaches will be most vulnerable to being overridden in medical settings.

Christian Scientists are a prime example. The Christian Science Church was founded by Mary Baker Eddy in the late 1800s, and the preponderance of Christian Scientists today are women, many of them older



women. Although the total number of Christian Scientists in the United States is comparatively small, most major cities have at least one active church with members of the congregation who are well established in their respective communities. One major difference between a Christian Scientist's approach to healing and that taken by members of more mainstream denominations is that Christian Scientists rely exclusively on prayer and do not attempt to "mix" prayer with a medical approach. They view the two approaches—prayer and medicine—as incompatible. Thus, Christian Scientists will usually refuse medical treatment for themselves and their children.

Nonetheless, Christian Science women find themselves in medical settings for a variety of reasons. Most states require that there be an attending physician during childbirth, and many types of birth control, including such "nonmedical" methods as the diaphragm, require a prescription. Christian Science mothers must take their children to physicians because school systems usually require physical examinations and vaccinations. Although a few Christian Science nursing facilities exist, many older Christian Science women requiring care are unable to avail themselves of these facilities. And of course, anyone, Christian Science or otherwise, can unexpectedly find herself in an emergency room without having requested to be taken there.

Christian Science women who have talked with me describe both subtle and overt ways that physicians discount and disregard their wishes. They are seldom believed when they report having experienced healings of "medical" conditions in the past. In cases where their children are diagnosed as having a serious condition, some physicians have attempted to obtain court orders to keep their children at the hospital. Many Christian Science women are scared or intimidated into obtaining medical treatment for themselves or their children because physicians "scold" them, exaggerate the risks associated with no treatment, or fail entirely to tell them their rights to refuse treatments. Because physicians assume that choosing a Christian Science approach to healing is tantamount to doing nothing at all, they feel professionally compelled to strongly urge if not actually compel the use of medical means for healing.

Obviously, Christian Scientists are not the only ones choosing alternative approaches to healing. But those who choose to *supplement* a medical approach with alternative spiritual approaches are less likely to have their decisions overridden. Most physicians do not view supplemental prayer as harmful to a patient, and may even acknowledge prayer's usefulness for maintaining an optimistic attitude. It is those women who *reject* a medical approach in favor of a religious approach that are most at risk for excessive



medical paternalism. When interacting with such women, physicians are apt to view themselves as objective and scientifically rational decision makers and to view their female religious patients as subjective and unscientifically irrational decision makers and thus as patients who do not know what is "best" for them.

### Creating Moral Space for Religious Women in Medical Settings

Unfortunately, many biomedical ethicists continue to believe that ethical expertise consists of mastering and then correctly applying bioethical principles. These bioethicists are, in turn, responsible for training the health care professionals who serve on ethics committees. New trends in bioethics are emerging, however. In a recent piece on health care ethics, Margaret Walker offers a way to conceive of ethics consulting that is, on my view, more responsive than traditional approaches to the moral concerns of religious women in medical settings. Walker proposes that those serving on ethics committees conceive of themselves as "architects of moral space" and as "mediators in the conversations taking place within that space" rather than as experts in "codelike theories and lawlike principles" (Walker 1993, 33).

As ethics consulting becomes less about attempting to apply (impose) "universal" secular principles, as it becomes more responsive to divergent worldviews and value systems, there will be a place within medical settings for religious perspectives. As evidenced by the examples cited above, however, both health care professionals and patients need facilitation and training in how best to express religious perspectives in settings where these views are not necessarily shared by others. Ethics committees, too, need this facilitation and training.

There are any number of reasons why those with religious leanings are reticent to discuss their religious views, even when such views are morally relevant. Some feel that bringing their religious beliefs into a discussion is tantamount to imposing these beliefs on others. Some feel that their religious commitments are intensely personal and private. Others do not wish to defend, or feel incapable of defending, their views to a skeptical and hostile group of individuals. Still others worry that they will lose ethical or professional credibility by appearing to be biased.

Nonetheless, there are some relatively simple techniques for bringing religious perspectives of moral relevance into ethics discussions. One is simply to preface what is said by making it clear that this is just one perspec-

tive out of many possible perspectives. Another is to make ample use of hypothetical statements, such as "If one takes the Catholic perspective, one might view the role of suffering as follows" or "If a patient believes that there is an afterlife, then that patient may view death not as an end but as a transition." An alternative approach is simply to note when secular assumptions are being made that may not be held by those with religious perspectives. For example, it can be pointed out when "health" is being conceived of in purely medical terms and that those with religious commitments would view health as incorporating both physical and spiritual well-being.

The first step, then, toward respecting and accommodating medically relevant views of older religious women is to recognize the importance of openly discussing these religious views and perspectives. Once this step has been taken, the discussants will need patience as they attempt to translate religious and secular terminologies, question what others take as givens, and publicly articulate what has previously been behind the scenes and private. This is not to say that they should ignore secular approaches to ethics. Rather, discussions of professional codes of ethics, philosophical ethical theories, and legal precedents should be supplemented with both feminist and religious approaches to ethical decision making.

## Notes

Special thanks to Margaret Walker and Robert Richardson for reading and commenting on earlier drafts of this chapter.

1. See, for example, Walker 1998, Held 1993, Bartky 1990, and Ruddick 1989.

2. One exception to this has been some discussion of whether religious "right-wing" women should be held morally accountable for promoting sexist values and advocating traditional subservient roles for women (see, for example, Superson 1995).

3. The *Hastings Center Report Special Supplement* (1990) contains one of the few discussions of the relationship between religion and bioethics. See, for example, Callahan 1990, Campbell 1990, Verhey 1990, and Wind 1990.

4. See Susan Wendell's chapter 8 in this volume on other aspects of women's lower cognitive authority in the eyes of medical professionals.

5. For more on the ethical issues that can arise when Christian Scientists interact with medical professionals see DesAutels, Battin, and May 1999.

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